021. PATIENT "ADVANCED DIRECTIVES". (4-30-92)

01. Provider Participation. Hospitals, nursing facilities, providers of home health care services (home health agencies, federally qualified health clinics, rural health clinics), hospice providers, and personal care R.N. supervisors must: (4-30-92)

a. Provide all adults receiving medical care written and oral information (the information provided must contain all material found in the Department's approved advanced directive form "Your Rights As A Patient To Make Medical Treatment Decisions") which defines their rights under state law to make decisions concerning their medical care. (4-30-92)

i. The provider must explain that the recipient has the right to make decisions regarding their medical care which includes the right to accept or refuse treatment. If the recipient has any questions regarding treatment, the facility or agency will notify the physician of those concerns. Their physician can answer any questions they may have about the treatment. (4-30-92)

ii. The provider will inform the recipient of their rights to formulate advance directives, such as "Living Will" and/or "Durable Power of Attorney For Health Care." (4-30-92)

iii. The provider must comply with Subsection 021.02. (4-30-92)

b. Provide all adults receiving medical care written information on the providers' policies concerning the implementation of the recipient's rights regarding "Durable Power of Attorney for Health Care," "Living Will," and the recipient's right to accept or refuse medical and surgical treatment. (4-30-92)

c. Document in the recipient's medical record whether the recipient has executed an advance directive ("Living Will" and/or "Durable Power of Attorney for Health Care") or, have a copy of the Department's approved advance directive form ("Your Rights as a Patient to Make Medical Treatment Decisions") attached to the patient's medical record which has been completed acknowledging whether the patient/resident has executed an advance directive ("Living Will" and/or "Durable Power of Attorney for Health Care"). (4-30-92)

d. The provider cannot condition the provision of care or otherwise discriminate against an individual based on whether that recipient has executed an "Advance Directive." (4-30-92)

e. If the provider cannot comply with the patient's "Living Will" and/or "Durable Power of Attorney for Health Care" as a matter of conscience, the provider will assist the recipient in transferring to a facility/provider that can comply. (4-30-92)

f. Provide education to their staff and the community on issues concerning advanced directives. (4-30-92)

02. When "Advanced Directives" Must Be Given. Hospitals, nursing facilities, providers of home health care (home health agencies, federally qualified health centers, rural health clinics), hospice agencies, and personal care R.N. supervisors, must give information concerning "Advanced Directives" to adult recipients in the following situations: (4-30-92)

a. Hospitals must give the information at the time of the recipient's admission as an inpatient unless Subsection 021.03. applies. (4-30-92)

b. Nursing facilities must give the information at the time of the recipient's admission as a resident. (4-30-92)

c. Home health providers must give the information to the recipient in advance of the recipient coming under the care of the provider. (4-30-92)

d. The personal care R.N. supervisors will inform the recipient when the R.N. completes the R.N. Assessment and Care Plan. The R.N. supervisor will inform the QMRP and the personal care attendant of the recipients decision regarding "Advanced Directives". (4-30-92)

e. A hospice provider must give information at the time of initial receipt of hospice care by the recipient. (4-30-92)

03. Information Concerning "Advanced Directives" at the Time an Incapacitated Individual is Admitted. An individual may be admitted to a facility in a comatose or otherwise incapacitated state and be unable to receive information or articulate whether he has executed an advance directive. In this case, to the extent that a facility issues materials about policies and procedures to the families or to the surrogates or other concerned persons of the incapacitated patient in accordance with state law, it must also include the information concerning advance directives. This does not relieve the facility from its obligation to provide this information to the patient once he is no longer incapacitated. (4-30-92)

04. Provider Agreement. The provider will sign a "Memorandum of Understanding Regarding Advance Directives" with the Department until the "Patient's Notification of Advanced Directives" is incorporated within the Provider Agreement. By signing the Memorandum of Understanding or the Medicaid Provider Agreement, the provider is not excused from its obligation regarding advanced directives to the general public per Section 1902(a) of the Social Security Act, as amended by Section 4751 of OBRA 1990. (4-30-92)

022. -- 024. (RESERVED).

025. LIENS. No lien or encumbrance of any kind is to be required from, or imposed against, the property of any person prior to his death because of MA paid or to be paid on his behalf, or at any time if he was under sixty-five (65) years of age when he received such MA benefits except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual. (11-10-81)

026. CONDITIONS FOR PAYMENT. (7-1-93)

01. Recipient Eligibility. The Department will reimburse providers for medical care and services, regardless of the current eligibility status of the MA recipient in the month of payment, provided that each of the following conditions are met: (11-10-81)

a. The recipient was found eligible for MA for the month, day, and year during which the medical care and services were rendered; and (11-10-81)

b. The recipient received such medical care and services no earlier than the third month before the month in which application was made on such recipient's behalf; and (11-10-81)

c. Not more than twelve (12) months have elapsed since the month of the latest recipient services for which such payment is being made. Medicare cross-over claims are excluded from the twelve (12) month submittal limitation. (11-10-81)

02. Time Limits. The time limit set forth in Subsection 026.01.c. shall not apply with respect to retroactive adjustment payments. (12-31-91)

03. Acceptance of State Payment. By participating in the Medical Assistance Program, providers agree to accept, as payment in full, the amounts paid by the Department for services to Medicaid recipients. Providers also agree to provide all materials and services without unlawfully discriminating

on the grounds of race, age, sex, creed, color, national origin, or physical or mental handicap. (3-22-93)

027. -- 029. (RESERVED).

030. THIRD PARTY LIABILITY. (7-1-93)

01. Determining Liability of Third Parties. The Department will take reasonable measures to determine any legal liability of third parties for the medical care and services included under the MA Program, the need for which arises out of injury, disease, or disability of an MA recipient. (11-10-81)

02. Third Party Liability as a Current Resource. In determining whether MA is payable, the Department is to treat any third party liability as a current resource when such liability is found to exist and payment by the third party has been made or will be made within a reasonable time. (11-10-81)

03. Withholding Payment. The Department must not withhold payment on behalf of an eligible MA recipient because of the liability of a third party when such liability, or the amount thereof, cannot be currently established or is not currently available to pay the recipient's medical expense. (11-10-81)

04. Seeking Third Party Reimbursement. The Department will seek reimbursement from a third party for MA when the party's liability is established after MA is granted, and in any other case in which the liability of a third party existed, but was not treated as a current resource, with the exceptions of absent parent without a second valid resource, prenatal, EPSDT, and EPSDT related services. (2-4-91)

a. The Department will seek reimbursement for MA from a recipient when a recipient's liability is established after MA has been granted; and (11-10-81)

b. In any other situation in which the recipient has received direct payment from any third party resource and has not returned the money to the Department for MA service received. (11-10-81)

05. Billing Third Parties First. Medicaid providers must bill all other sources of direct third party payment, with the exception of absent parent (court ordered) without secondary resources, prenatal, EPSDT and EPSDT related services before submitting the claim to the Department. If the resource is an absent parent (court ordered) and there are no other viable resources available or if the claims are for prenatal, EPSDT, or EPSDT related services, the claims will be paid and the resources billed by the Department. (2-4-91)

06. Accident Determination. When the patient's Medicaid card indicates private insurance and/or when the diagnosis indicates an accident for which private insurance is often carried, the claim will be suspended or denied until it can be determined that there is no other source of payment. (11-10-81)

07. Third Party Payments in Excess of Medicaid Limits. The Department will not reimburse providers for services provided when the amount received by the provider from the third party payor is equal to or exceeds the level of reimbursement allowed by MA for the services. (11-10-81)

08. Subrogation of Third Party Liability. In all cases where the Department will be required to pay medical expenses for a recipient and that recipient is entitled to recover any or all such medical expenses from any third party, the Department will be subrogated to the rights of the recipient to the extent of the amount of medical assistance benefits paid by the Department as the result of the occurrence giving rise to the claim against the third party. (11-10-81)

a. If litigation or a settlement in such a claim is pursued by the MA recipient, the recipient must notify the Department. (11-10-81)

b. If the recipient recovers funds, either by settlement or judgment, from such a third party, the recipient must repay the amount of benefits paid by the Department on his behalf. (11-10-81)

09. Subrogation of Legal Fees.

a. If an MA recipient incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim to which the Department is subrogated, the amount which the Department is entitled to recover, or any lesser amount which the Department may agree to accept in compromise of its claim, will be reduced by an amount which bears the same relation to the total amount of attorney fees and court costs actually paid by the recipient as the amount actually recovered by the Department, exclusive of the reduction for attorney fees and court costs, bears to the total amount paid by the third party to the recipient. (11-10-81)

b. If a settlement or judgment is received by the recipient which does specify portion of the settlement or judgment which is for payment of medical expenses, it will be presumed that the settlement or judgment applies first to the medical expenses incurred by the recipient in an amount equal to the expenditure for benefits paid by the Department as a result of the payment or payments to the recipient. (11-10-81)

031. MEDICAID COST RECOVERY FROM PARENTS. The Department intends to recover from a child's parent, all or part of the cost of Medicaid services to the child in a Nursing Facility (NF), in an Intermediate Care Facility for the Mentally Retarded (ICF/MR), or under Home Care for Certain Disabled Children (HCCDC). The child must be under eighteen (18). Recovery is from the child's natural or adoptive parent. Recovery is made under Sections 32-1003, 56-203B, and 56-209b, Idaho Code. Upon application for Medicaid, the applicant assigns to the State of Idaho his rights to recover payments for his medical expenses from any liable third party, including a parent. Recovery will not be made for a child receiving adoption assistance under Title IVE of the Social Security Act, or under the State Adoption Assistance Program. The Examiner must tell the parent(s) of a child applying for Medicaid help with NH, ICF/MR, or HCCDC, that he may be required to share in the cost of Medicaid services for the child. No eligible child will be denied Medicaid services if a responsible parent fails to pay the assessment. Medicaid payments to providers will not be reduced if the parent fails to pay. (7-6-94)

01. Parent Gross Assessment Income. Parent gross assessment income is the parents' adjusted gross federal income as reported on the last calendar year's federal income tax form 1040 or 1040A (Adjusted Gross Income). The figure on the line entitled "Adjusted Gross Income" of the 1040 or 1040A is for two-parent families whether filing jointly or separately. Where the child's custodial parent lives with the child's stepparent, the amount on the line entitled "Adjusted Gross Income" on the 1040 or 1040A must be adjusted by subtracting the stepparent's income. Parents who have not yet filed a tax return must provide an estimated adjusted gross income amount. The tax return must be provided when filed. Parents who claim this year's income is substantially different from their previous adjusted gross federal income must provide proof of their actual income. (7-6-94)

02. Stepparent Income. Where the parent's spouse is the child's stepparent, the parent's community property interest in the stepparent's income is not income to the parent for calculating the parent's assessment income (AI). (7-6-94)

03. Two Parent Assessment. Where the child's parents are living apart, each parent is separately assessed. The assessment of each parent is lowered, if necessary, so the total assessment for the child is not more than the Medicaid payments made for the child during the assessment year. (7-6-94)

monthly assessment and the parent's right to request an informal conference for an explanation of the recovery requirement and the assessment amount. (7-6-94)

11. Assessment Year. The first assessment year is the twelve month period beginning with the effective month of the child's eligibility for Medicaid in an NF or ICF/MR or under HCCDC. Subsequent assessment years are twelve month periods beginning the same calendar month as the first assessment year began. (7-6-94)

12. Assessment Limit. The total assessment for an assessment year will not exceed the Medicaid payments made for the child for the assessment year. (7-6-94)

13. Interim Adjustments. The assessment amount can be adjusted up to four (4) times during an assessment year, if the parent asks for recalculation, based on lower AI. The parent must prove his AI is lower than income used for the yearly assessment. Recalculation is not automatic when the assessment formula changes in January. (7-6-94)

14. Annual Adjustment. The AI is recalculated yearly in the same month as the initial assessment. The assessment is adjusted, if necessary. The parent must be sent a notice of the adjusted assessment. The parent can request an adjustment of the yearly assessment. The parent must provide a copy of his federal tax filing for that calendar year or other proof of annual income. The annual income is compared to the parent's AI for that tax year. If the AI is less than the AI used to calculate the assessment, the assessment is adjusted. (7-6-94)

15. Annual Reconciliation. The parent's assessment and the Medicaid cost excluding services provided by school districts or developmental disability centers for the child are reconciled at assessment year end. If the parent paid more than the Medicaid cost for the child, a credit is issued. If the child is no longer a Medicaid recipient, a refund is issued. Where a parent has more than one (1) child whose Medicaid costs are subject to recovery, the monthly assessment will be divided by the number of children whose costs are subject to recovery. Each child's prorated share of the assessment is then compared to the Medicaid costs for that child to determine whether a refund will be issued. No reconciliation is required where the difference between the projected AI and actual income for the tax year is a minimum of three thousand dollars ($3,000) or ten percent (10%) of annual AI, whichever is more. (7-6-94)

16. Annual Support Deduction Reconciliation. Where the parent paid more medical support than was deducted, he is entitled to a credit. If the child is no longer a recipient of NF, ICF/MR, or HCCDC Medicaid, the parent is entitled to a refund of the amount he overpaid. (7-6-94)

17. Payment Schedule. The parent may pay his annual assessment in four (4) payments yearly, for services already paid or projected to be paid by Medicaid. The parent may negotiate a different payment schedule with the TPR Unit. (7-6-94)

18. Enforcement. Failure of a responsible parent to pay the assessment will be referred to the Office of the Attorney General for initiation of collection proceedings and appropriate legal action, including civil suit, garnishment, attachment, and any other legal process to accomplish the purpose of Sections 32-1003, 56-2038 and 56-209b, Idaho Code. Collection will be enforced by the Bureau of Child Support Services (BCCS). (7-6-94)

19. Out-of-State Parents. Responsible parents living out-of-state will be contacted and assessed to the same extent as Idaho residents. The Department may enter into reciprocity of enforcement agreements with states with similar provisions. (7-6-94)

032. -- 035. (RESERVED).

036. REPORTING TO IRS. Pursuant to 26 USC 6041, the Department must provide annual information returns to the IRS showing aggregate amounts paid to providers identified by name, address, and social security number or employer identification number. (11-10-81)

037. -- 039. (RESERVED).

040. AGREEMENTS WITH PROVIDERS. (7-1-93)

01. In General. The Department will enter into written agreements with each provider or group of providers of supplies or services under the Program. Agreements may contain any terms or conditions deemed appropriate by the Department. Each agreement will contain, among others, the following terms and conditions requiring the provider: (3-2-94)

a. To retain for a minimum of three (3) years any records necessary for a determination of the services the provider furnishes to recipients; and (11-10-81)

b. To furnish to the Bureau, the Secretary of the U.S. Department of Health and Human Services, the Fraud Investigation Bureau, or the Department of Law Enforcement any information requested regarding payments claimed by the provider for services; and (11-10-81)

c. To furnish to the Bureau, the Secretary of the U.S. Department of Health and Human Services, the Fraud Investigation Bureau, or the Department of Law Enforcement, information requested on business transactions as follows: (11-10-81)

i. Ownership of any subcontractor with whom the provider has had business transactions of more than twenty-five thousand dollars ($25,000) during a twelve (12) month period ending on the date of request; and (11-10-81)

ii. Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor during the five (5) year period ending on the date of request. (11-10-81)

02. Federal Disclosure Requirements. To comply with the disclosure requirements in 42 CFR 455, Subpart B, each provider, other than an individual practitioner or a group of practitioners, must disclose to the Department: (11-10-81)

a. The full name and address of each individual who has either direct or indirect ownership interest in the disclosing entity or in any subcontractor of five percent (5%) or more prior to entering into an agreement or at the time of survey and certification; and (11-10-81)

b. Whether any person named in the disclosure is related to another person named in the disclosure as a spouse, parent, or sibling. (11-10-81)

03. Termination of Provider Agreements. Provider agreements may be terminated with or without cause. (3-2-94)

a. The Department may, in its discretion, terminate a provider's agreement for cause based on its conduct or the conduct of its employees or agents, when the provider fails to comply with any term or provision of the provider agreement. Other action may also be taken, based on the conduct of the provider as provided in IDAPA 16.03.09190, and notice of termination shall be given as provided therein. Terminations for cause may be appealed as a contested case pursuant to the Rules Governing Contested Case Proceedings and Declaratory Ruling, IDAPA 16.05.03000. et. seq. (3-2-94)

b. Due to the need to respond quickly to state and federal mandates, as well as the changing needs of the state plan, the Department may terminate provider agreements without cause by giving written notice to the provider as set forth in the agreement. If an agreement does not provide a notice period, it shall be twenty-eight (28) days.Terminations without may result from, but are not limited to, elimination or change of programs or requirements, or the provider's inability to continue providing services due to the actions of another agency or board. Terminations without cause are not subject to contested case proceedings since the action will either affect a class of providers, or will result from the discretionary act of another body. (3-2-94)

04. Hospital Agreements. In addition to the provider enrollment agreement, each claim submitted by a hospital constitutes an agreement by which the hospital agrees to accept and abide by the Department's rules. Only a Medicare certified hospital, licensed by the state in which it operates, may enroll in the Idaho Medicaid program. Hospitals not participating as a Medicaid swing-bed provider, which are licensed for long-term care or as a specialty hospital which provides a nursing home level of care, will be reimbursed as a nursing facility. Hospitals not eligible for enrollment which render emergency care will be paid rates established in Idaho Department of Health and Welfare Rules, Title 03, Chapter 10, Section 456., "Rules Governing Medicaid Provider Reimbursement." (3-22-93)

041. -- 044. (RESERVED).

045. ELIGIBILITY FOR MEDICAL ASSISTANCE. Idaho Department of Health and Welfare Rules, Title 3, Chapter 1, "Rules Governing Eligibility for Aid for Families with Dependent Children (AFDC)," and Idaho Department of Health and Welfare Rules , Title 3, Chapter 5, "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)," are applicable in determining eligibility for MA. (12-31-91)

046. -- 049. (RESERVED).

050. MEDICAL ASSISTANCE PROCEDURES. (7-1-93)

01. Issuance of Identification Cards. When a person is determined eligible for Medical Assistance pursuant to Idaho Department of Health and Welfare Rules, Title 3, Chapter 1, "Rules Governing Eligibility for Aid for Families with Dependent Children (AFDC)," and Idaho Department of Health and Welfare Rules, Title 3, Chapter 5, "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)," the Field Office must prepare and issue to that person a temporary identification card valid only for those dates designated on the card. When requested, the Field Office must give providers of medical services eligibility information regarding those persons with temporary cards. (12-31-91)

02. Identification Card Information. An identification card will be issued monthly after the original issuance to each recipient and will contain the following information: (11-10-81)

a. The names of all persons in the household eligible for MA; and (11-10-81)

b. Each recipient's sex, birthdate, and identification number, including the suffix; and (11-10-81)

c. The month, day, and year for which the card is valid; and (11-10-81)

d. For a recipient eligible for dental services, a "D" to so indicate; and (11-10-81)

e. For a recipient who has another insurance carrier, an asterisk (*) to so indicate. (11-10-81)

03. Information Available for Recipients. The following information will be available at each Field Office for use by each MA recipient: (11-10-81)

a. The amount, duration and scope of the available care and services; and (11-10-81)

b. The manner in which the care and services may be secured; and (11-10-81)

c. How to use the monthly identification card; and (11-10-81)

d. The appropriate billing procedures required by the Department. (11-10-81)

04. Residents of Other States. To the extent possible, the Department is to assist residents from other states in meeting their medical needs while in Idaho, regardless of whether the request for assistance originates from another state's welfare agency, from the person himself, or from a provider of medical care and services. (1-16-80)

05. Review of Records.

a. The Department, or its duly authorized agent, the U.S. Department of Health and Human Services, and the Fraud Investigation Bureau have the right to review pertinent records of providers receiving MA payments. (11-10-81)

b. The review of recipients' medical and financial records must be conducted for the purposes of determining: (11-10-81)

i. The necessity for the care; or (11-10-81)

ii. That treatment was rendered in accordance with accepted medical standards of practice; or (11-10-81)

iii. That charges were not in excess of the provider's usual and customary rates; or (11-10-81)

iv. That fraudulent or abusive treatment and billing practices are not taking place. (11-10-81)

c. Refusal of a provider to permit the Department to review MA pertinent records will constitute grounds for: (11-10-81)

i. Withholding payments to the provider until access to the requested information is granted; or (11-10-81)

ii. Suspending the provider's number. (11-10-81)

051. -- 054. (RESERVED).

055. GENERAL PAYMENT PROCEDURES. (11-10-81)

01. Hospital or Long Term Care. (11-10-81)

a. If an MA recipient's attending physician orders hospitalization or long term care services, the recipient must present his recipient identification card to the admission clerk. Where an identification card indicates that a recipient is enrolled in a coordinated care plan, the provider must obtain a referral from the primary care provider. Claims for services provided

to recipients designated as participating in coordinated care by other than the primary care provider, without proper referral, will not be paid (6-1-94)

b. The hospital or long term care facility must submit claims for care and services provided to the MA recipient on claim forms provided by the Department. (11-10-81)

c. The Central Office must process each claim form received and make payments directly to the hospital or long term care facility. (11-10-81)

d. Long term care facilities must request MA payment of the co-insurance portion of charges for Medicare eligible recipients only after the first twenty (20) days of care. (11-10-81)

02. Other Provided Services. (11-10-81)

a. Each recipient may consult a participating physician or provider of his choice for care and services within the scope of MA by presenting his recipient identification card to the provider, subject to restrictions imposed by a participation in a coordinated care plan. (6-1-94)

b. The provider must copy the required information from the identification card onto the appropriate claim form. Where an identification card indiciates that a recipient is enrolled in a coordinated care plan, the provider must obtain a referral from the primary care provider. Claims for services provided to recipient designated as participating in coordinated care by other than the primary care provider without proper referral, will not be paid. (6-1-94)

c. Upon providing the care and services to the MA recipient, the provider or his agent must complete the other sections of the appropriate claim form, sign the form, and mail the original of the form to the Central Office. (11-10-81)

d. The Central Office is to process each claim form received and make payment directly to the provider. (1-16-80)

e. The Department will not supply the Uniform Billing Form UB-82, Form 1500, and/or American Dental Association (ADA) Attending Dentist's Statement, or their replacements. Claim forms which will be supplied by the Department in order to meet the Department's unique data and billing requirements include Turn Around Documents (TDAs), the State Drug Claim Form, and the Blue Physician Invoice. (3-22-93)

03. Medicare Procedures. If a MA recipient is Medicare eligible, the provider must secure the necessary supporting Medicare documents from the fiscal intermediaries and attach the documents to the appropriate claim form prior to submission to the Central Office. (11-10-81)

04. Services Normally Billed Directly to the Patient. If a hospital provides outpatient diagnostic, radiological, or laboratory services, as ordered by the attending physician, and if it is customary for the hospital to bill patients directly for such services, the hospital must complete the appropriate claim form and submit it to the Bureau. (11-10-81)

056. -- 059. (RESERVED).

060. FEES AND UPPER LIMITS. (7-1-93)

01. Inpatient Hospital Fees. In reimbursing licensed hospitals, the Department will pay the lesser of customary charges or the reasonable cost of semi-private rates for in patient hospital care in accordance with Idaho Department of Health and Welfare Rules and Regulations, Title 3, Chapter 10, "Rules Governing Medicaid Provider Reimbursement in Idaho," however, the upper limits for payment must not exceed the payment which would be determined as

reasonable costs using the Title XVIII Medicare standards and principles. (12-31-91)

02. Outpatient Hospital Fees. The Department will not pay more than the combined payments the provider is allowed to receive from the beneficiaries and carriers or intermediaries for providing comparable services under comparable circumstances under Medicare. Out patient hospital service identified below that are not listed in the Department's fees schedule will be reimbursed reasonable costs will be based upon a year end cost settlement. (5-5-93)

a. Maximum payment for hospital out patient diagnostic laboratory services will be limited to the Department's established fee schedule. (5-5-93)

b. Maximum payment for out-patient hospital diagnostic radiology procedures will be limited to the Department's established fee schedule. (5-5-93)

c. Maximum payment for hospital out-patient partial care services will be limited to the Department's established fee schedule. (5-5-93)

e. Maximum payment for out-patient surgical procedures will be limited to the Department's fee schedule for ambulatory surgical centers. (5-5-93)

f. Hospital based abmulance services will be reimbursed according to the Department's established fee schedule for medical transportation. (5-5-93)

03. Long-Term Care Facility Fees. Long-term care facilities will be reimbursed the lower of their customary charges, their actual reasonable costs, or the standard costs for their class as set forth in the Provider Reimbursement Manual, but the upper limits for payment must not exceed the payment which would be determined as reasonable costs using the Title XVIII Medicare standards and principles. (11-10-81)

04. Individual Provider Fees. The Department will not pay the individual provider more than the lowest of: (11-10-81)

a. The provider's actual charge for service; or (11-10-81)

b. The maximum allowable charge for the service as established by the Department on its pricing file; or (11-10-81)

c. The Medicare upper limitation of payment on those services where a beneficiary is eligible under both programs and Medicaid is responsible only for the deductible and co-insurance payment. (11-10-81)

05. Fees for Other Noninstitutional Services. The Department will reimburse for all noninstitutional services which are not included in other Idaho Department of Health and Welfare Rules and Regulations, but allowed under Idaho's Medical Assistance Program according to the provisions of 42 CFR 447.325 and 42 CFR 447.352 and Section 1902(a)(13)(E) of the Social Security Act. (2-4-91)

061. -- 064. (RESERVED).

065. SERVICES NOT COVERED BY MEDICAL ASSISTANCE. The following services are not covered for payment by the Medical Assistance Program: (5-15-84)

01. Service Categories Excluded. The following categories of service are excluded from MA payment: (5-15-84)

a. Acupuncture services; and (5-15-84)